4684 Wenmar Drive
Saginaw, MI 48604
Ph: 989.793.1095

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Participate in the MI Syndromic Surveillance System that tracks the chief complaint of patients to identify public health threats before confirmed diagnoses are available. No personal patient information is captured.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as population health management and quality assessments utilizing Allscripts Professional EHR and other registries and Health Information Exchange systems..

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my child's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may request to pay out of pocket for any services and not have the services submitted to my child's health plan. At that time Caring Pediatric Partners will make a notation in your child's record of your request not to disclose the information regarding this service.

Patient Name: _____ D.O.B._____

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

WITNESS: _____ Date: _____

_____

OFFICE USE ONLY

On _____, _____ attempted to obtain the parent/guardian's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____	_____	_____
Date	Signature	Reason

Effective Date: March 1, 2021